

NMBH Las Vegas Incident Report Form

PRIMARY: CLIENT/STAFF INVOLVED

John Vigil

☒ Staff

☐ Aggressor ☐ Victim ☐ Witness

Date Incident Occurred

Time Incident Occurred

Date Discovered if Different than Date of Incident

5/29/2015

?

AM/PM

Division

- ☐ ADM
- ☐ APD
- ☐ CARE
- ☒ CBS
- ☐ Dietary
- ☐ FTU
- ☐ General Service
- ☐ Housekeeping/Laundry
- ☐ LTC
- ☐ NSG
- ☐ PLANT
- ☐ S&C
- ☐ Security/Safety
- ☐ Other

Unit

- ☐ APD - Choices/Isleta 1B
- ☐ APD - Cortez
- ☐ APD - Pinewood/Isleta 1A
- ☐ APD - Sierra
- ☐ APD - SPU/Isleta 2
- ☐ APD - Tesuque 1
- ☐ APD - Tesuque 2
- ☐ CARE
- ☐ CBS - Main
- ☐ CBS - Mora
- ☐ CBS - Pecos
- ☐ CBS - Santa Rosa
- ☒ CBS/ALF - El Paso
- ☒ CBS/ALF - MESA
- ☒ CBS/ALF - Vega
- ☐ FTU - B-Wing/WU
- ☐ FTU - Creston A/STOP
- ☐ FTU - Creston B/STOP
- ☐ FTU - C-Wing/ACU
- ☐ FTU - D-Wing/CCU
- ☐ FTU - MSU
- ☐ LTC - Aspen North
- ☐ LTC - Aspen South
- ☐ LTC - Evergreen North
- ☐ LTC - Evergreen South
- ☐ LTC - Juniper North
- ☐ LTC - Juniper South
- ☐ LTC - Ponderosa 1
- ☐ LTC - Ponderosa 2
- ☐ LTC - Ponderosa 3
- ☐ LTC - Ponderosa 4
- ☐ Other - Pinon
- ☐ Other - Zuni

CLIENT(s) INVOLVED

☐ Aggressor ☐ Victim ☐ Witness

☐ Aggressor ☐ Victim ☐ Witness

Received

☐ Aggressor ☐ Victim ☐ Witness

OTHER(s) INVOLVED

LINK

JUN 01 2015

☐ Staff

☐ Aggressor ☐ Victim ☐ Witness

Standard & Compliance

☐ Staff

☐ Aggressor ☐ Victim ☐ Witness

☐ Staff

☐ Aggressor ☐ Victim ☐ Witness

DESCRIPTION OF WHAT YOU SAW OR HEARD BEFORE & DURING INCIDENT (Staff with the most knowledge completes this section)

What was happening before the incident?

What happened during the incident?

Enter name of the person completing above section

Date Completed

PHYSICIAN/NURSE/SUPERVISOR ASSESSMENT/ACTION AND INTERVENTIONS TAKEN

Assessment/Treatment Summary

Immediate Action Taken at time of Incident (treatment/safety measures to protect and safeguard patient)

Please review attached letter - no name attached

Enter name of the person completing above section

Richard D. Vigil

Date Completed

6/1/15

PROBABLE CAUSE & PREVENTION

What was the cause or contributing factors?

Anonymous letter

Prevention measures or interventions taken to prevent recurrence:

*Recommend Investigation into matter*Was Treatment Plan Modified? ☐ Yes ☐ No ☐ N/A

Enter name of the person completing above section.

Charles Jaramillo

Date Completed

*6/1/15***INCIDENT TYPE - check all that apply**

TYPE OF INCIDENT	CONFLICT/ ASSAULTIVE BEHAVIOR	GRIEVANCE/ COMPLAINT BY
<input type="checkbox"/> No Injury <input type="checkbox"/> Injury - Patient <input type="checkbox"/> Injury - Staff <input type="checkbox"/> Injury - Unknown Origin <input type="checkbox"/> Minor Moderate Injury <input type="checkbox"/> Major/ Significant Injury - Fracture <input type="checkbox"/> Major/ Significant Injury - Joint Dislocation <input type="checkbox"/> Major/ Significant Injury - Head <input type="checkbox"/> Major/ Significant Injury - Altered Consciousness <input type="checkbox"/> Major/ Significant Injury - Subdural Hematoma <input type="checkbox"/> Death <input type="checkbox"/> Medical Condition <input checked="" type="checkbox"/> Other _____	<input type="checkbox"/> Patient vs Patient <input type="checkbox"/> Patient vs Staff <input type="checkbox"/> Staff vs Staff <input type="checkbox"/> Physical Contact <input type="checkbox"/> Verbal <input type="checkbox"/> Inappropriate Behavior <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient <input type="checkbox"/> Family/Guardian <input type="checkbox"/> Visitor
	ENVIRONMENT OF CARE	GRIEVANCE/ COMPLAINT TYPE
	<input type="checkbox"/> Fire/Hazard/Utilities <input type="checkbox"/> Grounds <input type="checkbox"/> Infection Control/Exposure <input type="checkbox"/> Property/Damage/Loss/Theft <input type="checkbox"/> Safety/Emergency <input type="checkbox"/> Other _____	<input type="checkbox"/> Clinical/Care/Meds <input type="checkbox"/> Conflict/Safety <input type="checkbox"/> Dietary/Food <input type="checkbox"/> Environment/Equip /Supplies <input type="checkbox"/> Financial <input type="checkbox"/> Interpersonal <input type="checkbox"/> Personal Items <input type="checkbox"/> Provider Preference <input type="checkbox"/> Services <input type="checkbox"/> Other _____
EMPLOYEE INJURY		
Was a Notice of Accident Form Completed? <input type="radio"/> Yes <input type="radio"/> No		
Was the Employee seen by NMBHI MD? <input type="radio"/> Yes <input type="radio"/> No		

CLASSIFICATION	DHI/ Other External	MISSING
<input type="checkbox"/> Accident <input type="checkbox"/> ER Visit <input type="checkbox"/> FALL <input type="checkbox"/> HIPAA <input type="checkbox"/> Hospitalization <input type="checkbox"/> HR Policy/Protocol Deviation <input type="checkbox"/> Patient Rule Deviation <input type="checkbox"/> Self Injury <input type="checkbox"/> Suicide Attempt/Ideation <input type="checkbox"/> X-Rays/CT Scans <input type="checkbox"/> Other _____ Fall <input type="checkbox"/> Report Fall Attached <input type="checkbox"/> On Falling Leaves Program	<input type="checkbox"/> Abuse <input type="checkbox"/> Exploitation <input type="checkbox"/> Injury of Unknown Origin (Significant) <input type="checkbox"/> Neglect <input type="checkbox"/> Significant Injury <input type="checkbox"/> Other (I.E. Emergency Disaster, Sexual Contact) _____	<input type="checkbox"/> Attempted Elopement <input type="checkbox"/> Attempted Escape - FTU <input type="checkbox"/> Elopement off Campus <input type="checkbox"/> Escape - FTU <input type="checkbox"/> Temporarily Missing <input type="checkbox"/> Unexpected Absence - CBS Time Discovered Missing _____ Time Returned _____ Was Law Enforcement Notified? <input type="radio"/> Yes <input type="radio"/> No Was Elopement Report Attached? <input type="radio"/> Yes <input type="radio"/> No <div style="border: 1px solid black; padding: 2px; text-align: center; font-weight: bold;">ON RETURN</div> Was Patient Assessed & Documented <input type="radio"/> Yes <input type="radio"/> No Was a Body Check Documented <input type="radio"/> Yes <input type="radio"/> No

Received

JUN 01 2015

Standard 3 Compliance
PATIENT ASSESSMENT

Client/Patient Name: Was the Client Patient? <input type="checkbox"/> Assessed <input type="checkbox"/> Injury Treated Was Nursing Assessment Completed? <input type="radio"/> Yes <input type="radio"/> No If Yes, Completed by Whom? If yes, Enter the Date:	Client/Patient Name: Was the Client Patient? <input type="checkbox"/> Assessed <input type="checkbox"/> Injury Treated Was Nursing Assessment Completed? <input type="radio"/> Yes <input type="radio"/> No If Yes, Completed by Whom? If yes, Enter the Date:	Client/Patient Name: Was the Client Patient? <input type="checkbox"/> Assessed <input type="checkbox"/> Injury Treated Was Nursing Assessment Completed? <input type="radio"/> Yes <input type="radio"/> No If Yes, Completed by Whom? If yes, Enter the Date:
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NOTIFICATION RECORD - Contacts made

	PERSON CONTACTED	DATE	TIME	CONTACT MADE BY
<input type="radio"/> Emergency "5555"				
<input type="radio"/> PBX 2100 or "0"				
<input type="radio"/> Security 2308				
<input type="radio"/> Safety 2345				
<input type="radio"/> Administrator/ Administrator on Call "0"				
<input type="radio"/> Nurse Administrator/ House Nurse 2227				
<input type="radio"/> On Call Physician "0"				
<input type="radio"/> Division Director				
<input type="radio"/> Internal Rev 228-4				
<input type="radio"/> Incident Call in 2442				
<input type="radio"/> S&C Incidents 2630				
<input type="radio"/> Housekeeping 2187				
<input type="radio"/> Plant 2250				
<input type="radio"/> Infection Control 2149				
<input type="radio"/> DHI/APS/CYFD/MCO/Law Enforcement/Other External, etc				
<input type="radio"/> Guardian, Family or Other				

I was told and everybody knows that supervisor John Vigil has a lot bottles of the patient's meds in his desk, and some are ativan and narcotics locked away. Also hundreds of dollars of their money to. John Vigil is the psych tech supervisor at the arches. We will send to HR patient advocate and investigations. You cannot tell him how you found out cause he will know who sent this letter.

Received
JUN 01 2015
Standard & Compliance



Revised 04/08/09

New Mexico Department of Health

DOH/DHI Use Only

HFL&C INCIDENT REPORT (SFY 2010) Case #:

HFL&C INCIDENT REPORT (SFY 2010) Case #: SECTION 1 - CONSUMER INFORMATION

Name of Consumer	First: [REDACTED]	Middle:	Last: [REDACTED]
Social Security #	[REDACTED]	Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	DOB: [REDACTED]
Residence Address	Street Address: 3695 Hot Springs Blvd	City: Las Vegas	Zip: NV Phone: 505-454-2400

Consumer Competency Level	ADLs (Resident Needs Assistance With) Check All That Apply
<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low	<input type="checkbox"/> Walking <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bathing <input type="checkbox"/> Eating <input type="checkbox"/> Transfer <input type="checkbox"/> Total Care <input checked="" type="checkbox"/> None Verbal <input type="checkbox"/> Yes <input type="checkbox"/> No

Diagnosis(es): Schizophrenia - chronic - Borderline Intellectual Function - Asthma
 Name of Doctor & Phone: Dr. Milton

SECTION 2 - DESCRIPTION OF INCIDENT (Staff person with the most direct knowledge of incident fills out this section.)

TYPE OF ALLEGED INCIDENT

<input type="checkbox"/> Abuse	<input type="checkbox"/> Neglect	<input checked="" type="checkbox"/> Exploitation	<input type="checkbox"/> Injuries of Unknown Origin
Person responsible for individual's care at time of incident: NM SHI STAFF AT ASSISTED LIVING FACILITY			
Has this happened before? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Was anyone else present at the time of the incident: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Identify below:			
Name:	Title or Relationship:	Phone:	
Name:	Title or Relationship:	Phone:	
Date Incident Occurred: DATE REPORTED 06/03/15	Time: 11:30 AM	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Unknown	

Before the Incident:

An Anonymous Letter was received today at Standards & Compliance, Human Resources & to the patient advocate. It was Routed through Interoffice Mail.

During the Incident:

See Attached Letter.
 MR JOHN VIGIL IS THE psych tech Supervisor on the 7-3 shift at the ALF (Adult Living Facility). The ALF is located on NM SHI grounds.

DOH-HFL&C FAX (888-576-0012)

FOR CARE CLIENTS: FAX TO CYFD-LCA: 505-827-4595

When faxing information that is not on this form please label it with resident's name and incident date.

INCIDENT REPORT Page 1 of 3

Case # 15-66-66

Assigned to P. Schneider
on 6-4-15

Due 6-10-15

Name of Consumer	First: [REDACTED]	Middle: [REDACTED]	Last: [REDACTED]	SSN: [REDACTED]	Date of Incident: 0248
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After the Incident: Security Supervisor, Internal Review Director and 2 (Executive Nurse Administrators) went to Mr. Vigil's office. Mr. Vigil is currently on VACATION. We found that he had some cabinets above his desk that had a pad lock. Security broke the lock, we did find a bottle (Rx) that contained pills, the label was for Risperidone for [REDACTED] an add-on; there were two 90 pills.

Person Completing Sections 1 & 2

Confidentiality Desired: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Frances Tweed	Agency: NMBHI	Title/Relationship: Executive Nurse Administrator	Phone: 505 454 2604	Date Completed: 06/03/15	Time Completed: 1500
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SECTION 3 - AGENCY / FACILITY INFORMATION

Reporting Agency: NMBHI	Incident Coordinator: Marlene Martinez, Quality Manager Standards & Compliance			
Address: 3695 Hot Springs Blvd.	City: Las Vegas, NM	Zip: 87701	County: San Miguel	Phone:

SECTION 4 - ADMINISTRATIVE INFORMATION* Check the applicable box(s) below:

☐ ICFMR ☐ Diagnostic & Treatment Facility ☐ Limited Diagnostic & Treatment Facility ☐ Specialty Hospital
☐ Adult Residential Care Facility ☐ Home Health ☐ Hospice ☐ Nursing Facility ☒ Other ALF

INITIAL ACTIONS TAKEN BY THE AGENCY/FACILITY TO ASSURE HEALTH & SAFETY:

Review of the Record verified that patient has been receiving her Scheduled Dosing of Risperidone at 8 pm. Resident was assessed by Mabel Arguello - Vasquez RN. Vital Signs were stable at 97° 91 - 20 94 100 02 Sat 93% on RA

PLANS FOR FURTHER ACTIONS IN RESPONSE TO THE INCIDENT:

Resident will be monitored by staff at the Assisted Living Facility. This case will be investigated by our Internal Review Department

SECTION 5 - NOTIFICATIONS

Always notify DOH/DHI within 24 hours via FAX: (888-576-0012) or e-mail: incident.management@state.nm.us

Legal Guardian	Guardian Name & Phone #:	Date:	Time:	Person Making Contact:
<input checked="" type="checkbox"/> None N/A	Street Address:	City:	State:	Zip:
<input checked="" type="checkbox"/> Notified en r	Name & Phone #:	Date:	Time:	Person Making Contact:
Other	Street Address:	City:	State:	Zip:
<input type="checkbox"/> None				
<input type="checkbox"/> Notified				

Person Completing Sections 3, 4 & 5:

Name: Frances Tweed RN	Title/Relationship: Executive Nurse Administrator	Phone: 505 454-2604	Date Completed: 6/3/15	Time Completed: 1500
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By typing your name below you are effectively signing this document. Your typed name is acceptable as a replacement for your written signature.

Name: [Signature] Date: 06/03/15

Revised 04/08/09

New Mexico Department of Health

DOH/DHI Use Only

HFL&C INCIDENT REPORT (SFY 2010) Case #: SECTION 1 - CONSUMER INFORMATION

Name of Consumer	First	Middle:	Last
Social Security #	Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		DOB
Residence Address	Street Address: 3695 Hot Springs Blvd	City: Las Vegas	Zip: 87701 Phone: 505-
Consumer Competency Level	ADLs (Resident Needs Assistance With) Check All That Apply		
<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low	<input type="checkbox"/> Walking <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bathing <input type="checkbox"/> Eating <input type="checkbox"/> Transfer <input type="checkbox"/> Total Care <input checked="" type="checkbox"/> None Verbal <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Diagnosis(es): Schizotypal Plo. OCD -			
Name of Doctor & Phone Dr Brown			

SECTION 2 - DESCRIPTION OF INCIDENT (Staff person with the most direct knowledge of incident fills out this section.)

TYPE OF ALLEGED INCIDENT

☐ Abuse☐ Neglect☒ Exploitation☐ Injuries of Unknown Origin

Person responsible for individual's care at time of incident: NMSHI Assisted Living Facility

Has this happened before? ☐ Yes ☒ No

Was anyone else present at the time of the incident: ☐ Yes ☒ No If Yes, Identify below:

Name:	Title or Relationship:	Phone:
Name:	Title or Relationship:	Phone:
Date Incident Occurred: Date Reported 06/03/10	Time: 11:30 AM	<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Unknown

Before the Incident:

An anonymous letter was received today via interoffice mail. It was received by Standards & Compliance, Human Resources & the patient Advocate.

During the Incident:

See Attached Letter.
Mr. John Vigil is the psych tech Supervisor on the 7-3 shift at the ALF (Adult Living Facility). The ALF is located on NMSHI grounds.

DOH-HFL&C FAX (888-578-0012)

FOR CARE CLIENTS: FAX TO CYFD-LCA: 505-827-4595

When faxing information that is not on this form please label it with resident's name and incident date.

INCIDENT REPORT Page 1 of 3

Additional
Information for
case # 15-06-06

Name of Consumer	First: [REDACTED]	Middle: [REDACTED]	Last: [REDACTED]	SSN: [REDACTED]	Date of Incident: 06/03/15
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After the Incident: Security Supervisor, Internal Review Director, and (Executive Nurse Administrator) went to Mr. Vigil's office. Mr. Vigil is currently on vacation. We found that he did have some cabinets open his desk that had a pad lock. Security Supervisor broke the lock. We found a bottle (Rx) that contained pills. The label was for Risperidone [REDACTED]. In addition we found 2 ⁹¹/bills

Person Completing Sections 1 & 2

Confidentiality Desired: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name:	Agency: NMBHI	Title/Relationship:	Phone:	Date Completed:	Time Completed:
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SECTION 3 - AGENCY / FACILITY INFORMATION

Reporting Agency: NMBHI	Incident Coordinator: Marlene Martinez, Quality Manager Standards & Compliance			
Address: 3895 Hot Springs Blvd.	City: Las Vegas, NM	Zip: 87701	County: San Miguel	Phone:

SECTION 4 - ADMINISTRATIVE INFORMATION* Check the applicable box(s) below:

- ☐ ICFMR ☐ Diagnostic & Treatment Facility ☐ Limited Diagnostic & Treatment Facility ☐ Specialty Hospital
☐ Adult Residential Care Facility ☐ Home Health ☐ Hospice ☐ Nursing Facility ☒ Other ART

INITIAL ACTIONS TAKEN BY THE AGENCY/FACILITY TO ASSURE HEALTH & SAFETY:

Review of resident's record revealed that resident has been receiving her PM dose of Risperidone. Resident was assessed by Nurse Arguillo-Vazquez per policy, vital signs stable at 97°-78-20 O2 Sat 94% RA SpO2 = 110/70

PLANS FOR FURTHER ACTIONS IN RESPONSE TO THE INCIDENT:

Resident will continue to be monitored by ART STAFF.
This Allegation will be investigated by NMBHI
Internal Review Department

SECTION 5 - NOTIFICATIONS

Always notify DOH/DHI within 24 hours via FAX: (888-576-0012) or e-mail: incident.management@state.nm.us

Legal Guardian	Guardian Name & Phone #:	Date:	Time:	Person Making Contact:
<input checked="" type="checkbox"/> None <u>N/A</u>	Street Address:	City:	State:	Zip:
<input type="checkbox"/> Notified	Name & Phone #:	Date:	Time:	Person Making Contact:
Other	Street Address:	City:	State:	Zip:
<input type="checkbox"/> None				
<input type="checkbox"/> Notified				

Person Completing Sections 3, 4 & 5:

Name:	Title/Relationship:	Phone:	Date Completed:	Time Completed:
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By typing your name below you are effectively signing this document. Your typed name is acceptable as a replacement for your written signature.

Name:

[Signature]

Date:

06/03/15

I was told and everybody knows that supervisor John Vigil has a lot bottles of the patientes meds in his desk, and some are atvans and narcotics locked away. Also hundreds of dollars of there money to. John Vigil is the psych tech supervisor at the arches. We will send to HR patient avocate and investigations. You cannot tell him how you found out cuase he will know who send this letter.